BEHAVIORAL HEALTH PROVIDER NETWORK APPLICATION

Instructions:

- This form should be typed or completed legibly in blue or black ink.
- All Sections and fields must be completed to be considered for review.
- If you need additional space, please attach additional sheets, which reference the question(s) being answered.
- Please email the completed application with the additional supporting documents to contracts@gobhi.org

Section 1: Provider Information

Legal Business Name:		**Doing Business As (DBA) (if applicable):**
Primary Contact Name:		**Email:** **Phone:**
Primary Provider / Facility Street Address:		
City:	**State:**	**ZIP Code:**
ADA COMPLIANCE: *(Compliant, Limited, None)*		
PLEASE COMPLETE IF YOU HAVE MULTIPLE SERVICE LOCATIONS.		
Additional Facility Street Address:		
City:	**State:**	**ZIP Code:**
ADA COMPLIANCE: *(Compliant, Limited, None)*		
Additional Facility Street Address:		
City:	**State:**	**ZIP Code:**
ADA COMPLIANCE: *(Compliant, Limited, None)*		
PLEASE LIST ALL NUMBERS AND CODES THAT WILL BE USED FOR BILLING.		
Tax Identification Number:		**Provider NPI Number:**
DMAP Number:		**Taxonomy Code:**

Section 2: Provider Services *(This should reflect services intended to be provided for EOCCO members)*

Behavioral Health Service Type(s):	☐ Outpatient Mental Health ☐ Outpatient Substance Use Disorder ☐ Psych Testing ☐ PHP/IOP ☐ Medical Detox ☐ Adolescent Residential ☐ Adolescent PHP ☐ Adolescent IOP ☐ Adult Residential ☐ Adult PHP ☐ Adult IOP ☐ Medication Assisted Treatment (MAT) ☐ Eating Disorder Treatment ☐ Other (Detail Below)
Please list and describe any additional services not captured above:	
Procedure Codes to be Billed:	

Section 3: Provider Licensing / Credentialing

Certificate(s) of Approval (COA)	**Certificate Type(s)**	**Expiration Date(s)**
Practitioner Licenses	**Practitioner Name(s)**	**License Type(s)**
Culturally and Linguistically Specific Services (CLSS) Designations	**CLSS Type** (Ex… Muslim, LGBTQIA2S+, LatinX)	☐ Individual Provider ☐ CLS Organization ☐ CLS Service Program
Bilingual Practitioner(s)	**Practitioner Name(s)**	**Languages**
OHA Healthcare Interpreter Designations	**Practitioner Name(s)**	**Qualified or Certified**

Section 4: Provider Capacity, Service Delivery, Service Location

How many EOCCO members do you currently serve?	
How many EOCCO members do you have the capacity to serve?	
What counties do the EOCCO members you currently serve reside in?	
What EOCCO counties are you intending to serve?	
Services provided are…	☐ In Person ☐ Telehealth ☐ Both

Section 5: Readiness Questionnaire

Do you or your organization have any open or existing disciplinary actions?

☐ No
☐ Yes

Do you or your organization offer the same hours of operation and appointment times for all clients regardless of insurance type?

☐ No
☐ Yes

Do you or your organization have intake and documents available in alternate formats (audio, braille, large print, etc.)?

☐ No
☐ Yes

Do you or your organization have an organizational understanding of Medicaid and EOCCO billing requirements, and internal or external support to file accurate and timely claims?

☐ No
☐ Yes

Do you or your organization have an understanding of medical necessity and the capacity to document services that meet professional standards and billing requirements?

- [ ] No
- [ ] Yes

Do you or your organization have existing infrastructure to meet security requirements for PHI both at rest and in transit?

- [ ] No
- [ ] Yes

Do you or your organization have a functioning Compliance Program, or designated individual responsible for Compliance oversight?

- [ ] No
- [ ] Yes

Do you or your organization have a functioning Quality Assurance (QA) Program, or designated individual responsible for QA oversight?

- [ ] No
- [ ] Yes

Do you or your organization have an existing grievance procedure and process that meets requirements?

- [ ] No
- [ ] Yes

Do you or your organization have the capacity and structure to provide care coordination as needed with EOCCO and the EOCCO members service providers?

- [ ] No
- [ ] Yes

Do you or your organization utilize a Social Determinants of Health (SDOH) Needs Screening tool and support the connection for members with SDOH needs to available supports?

- [ ] No
- [ ] Yes